Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Memorial Hermann Hospital System
3200 SW Freeway Ste 2200
Houston, TX 77027

Sent
MAY 13 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

MFDR Tracking #: M4-07-1242-01

DWC Claim #:

Injured Employee:

Date of Injury:

Employer:

Insurance Carrier:

Respondent Name and Box #:

Insurance Co of The State of P
Rep Box # 19

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Please accept this letter as the Requestor's response to the carrier's Motion to Dismiss filed on November 22, 2006. The carrier's Motion to Dismiss is clearly without merit. Attached to the request for medical dispute resolution is a copy of the hospital's request for reconsideration which was filed within one year of the date of service. The carrier suggests that the provisions of 28 Texas Administrative Code §133.304 provides a time frame outlined in the rule. The hospital's request for reconsideration was made within one year from the date of service and the subject invoices for the implantables were also provided to the carrier within one year of the date of service. Since the carrier has not responded to these amounts owed on this claim, the hospital was required to file the instant request for medical dispute resolution. Since all of these things occurred within one year from the date of service, the hospital's request is meritorious and timely..."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $2,887.28
3. UB-92
4. EOBs
5. Implant Invoice

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "...The DOS in dispute are 10/28/05-10/29/05. Requestor did not file documentation necessary to determine the amounts due for implantables under the ACIHFG with its initial submission of the bill. That completeness defect was pointed out by the Carrier in its initial EOB of 1/12/06. Requestor did not file a Request for Reconsideration timely in accordance with 28 TAC § 133.304 (repealed) or current § 133.250. An attempt to submit a RFR was made on 10/05/06. Even that was ineffectual as it still was incomplete because of the failure to include the invoices for the implantables: Those invoices were not supplied until the afternoon of 10/11/06. The RFR was not timely. As a result, the Requestor filed this dispute even before the Carrier response time to a complete bill and proper RFR..."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/28/05 thru 10/29/05	Implantables (See Calculations Below)	W1, 16	1-4	$00.00
Total /Due:				$00.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.401, titled *Acute Care Hospital Inpatient Fee Guideline*, effective August 1, 1997, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code:
   - "16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
   - W1 – Workers Compensation State Fee Schedule adjustment."
2. Reimbursement for hospital inpatient services provided on or after August 1, 1997 are subject to 28 Texas Administrative Code §134.401, Acute Care Inpatient Hospital Fee Guidelines. Reimbursement for inpatient hospital services in which the total audited charges is less that $40,000, is calculated based upon a standard per diem amount for acute care impatient services as follows: Medical --S870 per day; Surgical -- $1,118 per day; Intensive Care unit (ICU)/Cardiac Care Unit (CCU) $1,560 per day. Additional reimbursement is allowed as follows: Implantables and Orthotics/Prosthetics are paid at the hospital cost plus 10%.
3. Total audited charges for dates of service 10/28/05 thru 10/29/05 do not exceed $40,000 dollars. Review of the UB-92 indicates that this hospital admission was for surgery and did not have a primary diagnosis of Trauma, Burns or HIV and is therefore payable using the per diem methodology listed in item #1 above. The Respondent made payment in the amount of $1,118.00.
4. The Requestor billed $6,919.57 for implantables used during the procedure performed on 10/28/05. The Requestor did a request for reconsideration on 10/05/06. The implant invoice was received by the Respondent on 10/11/06. The dispute was received in Medical Fee Dispute Resolution on 10/26/06. Per Rule 133.304(m)(2), the Requestor did not give the Respondent proper time to respond to the request for reconsideration; therefore, no additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1,
28 Texas Administrative Code §134.401
28 Texas Administrative Code §133.304

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	5/12/2008 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.